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Supreme Court of the United States

OCTOBER TERM, 1982

THOMAS A. BAREFOOT,
Petitioner,

v.

W. J. ESTELLE, JR., Director
Texas Department of Corrections,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF AMICUS CURIAE FOR THE AMERICAN PSYCHIATRIC ASSOCIATION

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BRIEF AMICUS CURIAE FOR THE AMERICAN PSYCHIATRIC ASSOCIATION

INTEREST OF AMICUS CURIAE

The American Psychiatric Association, founded in 1844, is the nation's largest organization of qualified doctors of medicine specializing in psychiatry. Almost 27,000 of the nation's approximately 34,000 psychiatrists are members. The Association has participated as amicus curiae in numerous cases involving mental health issues, including *Youngberg v. Romeo*, 102 S. Ct. 2452 (1982), *Mills v. Rogers*, 102 S. Ct. 2442 (1982), *Estelle v. Smith*, 101 S.

Ct. 1866 (1981), *Parham v. J.R.*, 442 U.S. 584 (1979), *Addington v. Texas*, 441 U.S. 418 (1979), and *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

The American Psychiatric Association has been actively involved in examining the role of psychiatrists in predicting future violent behavior and the relationship of those predictions to a variety of legal matters including civil commitment and discharge, the release of persons acquitted by reason of insanity, and the administration of capital punishment statutes. On the basis of these studies the Association believes that it can make an important contribution to the Court's consideration of the issues presented in this case. Resolution of those issues, moreover, will have a significant impact on the overall social and legal responsibility assigned to psychiatrists for predicting violent behavior and the methods that psychiatrists use in such endeavors.

The parties have consented to the filing of this brief. Their letters of consent have been filed with the Clerk.

STATEMENT

Petitioner Thomas A. Barefoot stands convicted by a Texas state court of the August 7, 1978 murder of a police officer—one of five categories of homicides for which Texas law authorizes the imposition of the death penalty. *See* Tex. Penal Code § 19.03. Under capital sentencing procedures established after this Court's decision in *Furman v. Georgia*, 408 U.S. 238 (1972), the "guilt" phase of petitioner's trial was followed by a separate sentencing proceeding in which the jury was directed to answer three statutorily prescribed questions. *See* Tex. Code Crim. Proc. Art. 37.071. One of these questions—and the only question of relevance here—directed the jury to determine:

> whether there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society.

The jury's affirmative response to this question resulted in petitioner being sentenced to death.

The principle evidence presented to the jury on the question of petitioner's "future dangerousness" was the expert testimony of two psychiatrists, Dr. John T. Holbrook and Dr. James Grigson, both of whom testified for the prosecution.[1] Petitioner elected not to testify in his own defense. Nor did he present any evidence or testimony, psychiatric or otherwise, in an attempt to rebut the state's claim that he would commit future criminal acts of violence.

Over defense counsel's objection, the prosecution psychiatrists were permitted to offer clinical opinions regarding petitioner, including their opinions on the ultimate issue of future dangerousness, even though they had not performed a psychiatric examination or evaluation of him. Instead, the critical psychiatric testimony was elicited through an extended hypothetical question propounded by the prosecutor. On the basis of the assumed facts stated in the hypothetical, both Dr. Holbrook and Dr. Grigson gave essentially the same testimony.

First, petitioner was diagnosed as a severe criminal sociopath,[2] a label variously defined as describing persons

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[1] In addition, the prosecution called several character witnesses who testified to petitioner's "bad reputation" in various communities in which he had lived.

[2] Drs. Grigson and Holbrook used the terms "sociopath" and "antisocial personality disorder" interchangeably. Although the terms are not defined in precisely the same manner, the diagnosis of "sociopath" has been replaced in psychiatric nomenclature by "antisocial personality disorder." The diagnostic criteria for antisocial personality disorder are discussed below at pages 22-23. In general, antisocial personality disorder is characterized by "a history of continuous and chronic antisocial behavior in which the rights of others are violated, persistence into adult life of a pattern of antisocial behavior that began before the age of fifteen, and failure to sustain good job performance over a period of several years . . ." Childhood manifestations of antisocial behavior include

who "lack a conscience" (Grigson, Tr. 2128),[3] and who "do things which serve their own purposes without regard for any consequences or outcomes to other people." (Holbrook, Tr. 2098). Second, both psychiatrists testified that petitioner would commit criminal acts of violence in the future. Dr. Holbrook stated that he could predict petitioner's future behavior in this regard "within reasonable psychiatric certainty." (Tr. 2100). Dr. Grigson was more confident, claiming predictive accuracy of "one hundred percent and absolute." (Tr. 2131).

The prosecutor's hypothetical question consisted mainly of a cataloguing of petitioner's past antisocial behavior, including a description of his criminal record. In addition, the hypothetical question contained a highly detailed summary of the prosecution's evidence introduced during the guilt phase of the trial, as well as a brief statement concerning petitioner's behavior and demeanor during the period from his commission of the murder to his later apprehension by police.

In relevant part, the prosecutor's hypothetical asked the psychiatrists to assume as true the following facts:[4] First, that petitioner had been convicted of five criminal

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"lying, stealing, fighting, truancy, and resisting authority." Adolescent characteristics include "unusually early or aggressive sexual behavior, excessive drinking, and use of illicit drugs." In adulthood, this type of behavior typically continues, "with the addition of inability to sustain consistent work performance or to function as a responsible parent and failure to accept social norms with respect to lawful behavior." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 318 (3d ed. 1980).

[3] All transcript citations are to the original trial court transcript of the sentencing proceeding.

[4] The prosecutor stated the hypothetical question twice in the presence of the jury, once in his direct examination of Dr. Holbrook and again in his direct examination of Dr. Grigson. The two versions of the hypothetical are substantially the same. References in the text are to the version propounded to Dr. Grigson.

offenses—all of them nonviolent, as far as the record reveals[5]—and that he had also been arrested and charged on several counts of sexual offenses involving children. (Tr. 2112-13, 2120-21). Second, that petitioner had led a peripatetic existence and "had a bad reputation for peaceful and law abiding citizenship" in each of eight communities that he had resided in during the previous ten years. (Tr. 2113-14). Third, that in the two-month period preceding the murder, petitioner was unemployed, spending much of his time using drugs, boasting of his plans to commit numerous crimes, and in various ways deceiving certain acquaintances with whom he was living temporarily. (Tr. 2114-17). Fourth, that petitioner had murdered the police officer as charged, and that he had done so with "no provocation whatsoever" by shooting the officer in the head "from a distance of no more than six inches." (Tr. 2119). And fifth, that subsequent to the murder, petitioner was observed by one witness, "a homosexual," who stated that petitioner "was not in any way acting unusual or that anything was bothering him or upsetting him . . ." (Tr. 2124).

Testimony of Dr. Holbrook

Dr. Holbrook was the first to testify on the basis of the hypothetical question. He stated that the person described in the question exhibited "probably six or seven major criterias (*sic*) for the sociopath in the criminal area within reasonable medical certainty." (Tr. 2099). Symptomatic of petitioner's sociopathic personality, according to Dr. Holbrook, was his consistent "antisocial behavior" from "early life into adulthood," his willingness to take any action which "serves [his] own purposes" without any regard for the "consequences . . . to other people," and his demonstrated failure to establish any

[5] The stated offenses were possession of an unregistered firearm, distribution of marijuana, possession of amphetamines, carrying a concealed weapon, and possession of marijuana. Tr. 2111-13.

"loyalties to the normal institutions such as family, friends, politics, law or religion." (Tr. 2098).

Dr. Holbrook explained that his diagnosis of sociopathy was also supported by petitioner's past criminal violence and "serious threats of violence," as well as an apparent history of "escaping or running away from authority" rather than "accepting a confrontation in the legal way in a court of law." (Tr. 2099). And finally, Dr. Holbrook testified that petitioner had shown a propensity to "use other people through lying and manipulation . . ." (Tr. 2098). According to Dr. Holbrook, by use of such manipulation the sociopath succeeds in "enhancing [his] own ego image . . . It makes [him] feel good." *Ibid.*

After stating his diagnosis of sociopathy, Dr. Holbrook was asked whether he had an "opinion within reasonable psychiatric certainty as to whether or not there is a probability that the Thomas A. Barefoot in that hypothetical will commit criminal acts of violence in the future that would constitute a continuing threat to society?" (Tr. 2100). Without attempting to explain the implied clinical link between his diagnosis of petitioner and his prediction of future dangerousness, Dr. Holbrook answered simply: "In my opinion he will." (Tr. 2101).

Testimony of Dr. Grigson

On the basis of the prosecutor's hypothetical question, Dr. Grigson diagnosed petitioner as "a fairly classical, typical, sociopathic personality disorder" of the "most severe category." (Tr. 2128-29). The most "outstanding characteristic" of persons fitting this diagnosis, according to Dr. Grigson, is the complete "lack of a conscience." (Tr. 2128). Dr. Grigson stated that such persons "repeatedly break the rules, they con, manipulate and use people, [and] are only interested in their own self pleasure [and] gratification." *Ibid.*

Although Dr. Grigson testified that some sociopathic individuals do not pose a continuing threat to society, he

characterized petitioner as "your most severe sociopath." (Tr. 2129). Dr. Grigson stated that persons falling into this special category are "the ones that . . . have complete disregard for another human being's life." *Ibid.* Dr. Grigson further testified that "there is not anything in medicine or psychiatry or any other field that will in any way at all modify or change the severe sociopath." *Ibid.*

The prosecutor then asked Dr. Grigson to state his opinion on the ultimate issue—"whether or not there is a probability that the defendant . . . will commit criminal acts of violence that would constitute a continuing threat to society?" (Tr. 2131). Again, without explaining the basis for his prediction or its relationship to the diagnosis of sociopathy, Dr. Grigson testified that he was "one hundred percent" sure that petitioner "most certainly would" commit future criminal acts of violence. *Ibid.* Dr. Grigson also stated that his diagnosis and prediction would be the same whether petitioner "was in the penitentiary or whether he was free." *Ibid.*

INTRODUCTION AND SUMMARY OF ARGUMENT

The questions presented in this case are the logical outgrowth of two prior decisions by this Court. In the first, *Jurek v. Texas*, 428 U.S. 262 (1976), the Court dealt with the same Texas capital sentencing procedure involved here. The Court there rejected a constitutional challenge to the "future dangerousness" question, ruling that the statutory standard was not impermissibly vague. Although recognizing the difficulty inherent in predicting future behavior, 428 U.S. at 274, the Court held that "[t]he task that [the] jury must perform . . . is basically no different from the task performed countless times each day throughout the American system of criminal justice." 428 U.S. at 276. The *Jurek* Court thus upheld the use of the Texas statutory question, but did not consider the types of evidence that could be presented to the jury for purposes of this determination.

Subsequently in *Estelle v. Smith*, 101 S. Ct. 1866 (1981), the Court again dealt with the Texas sentencing scheme—this time in the context of a psychiatric examination to determine the defendant's competency to stand trial. The Court held that the Fifth Amendment's privilege against self-incrimination applied to such psychiatric examinations, at least to the extent that a prosecution psychiatrist later testifies concerning the defendant's future dangerousness. The Court reasoned that although a defendant has no generalized constitutional right to remain silent at a psychiatric examination properly limited to the issues of sanity or competency, full *Miranda* warnings must be given with respect to testimony concerning future dangerousness because of "the gravity of the decision to be made at the penalty phase, . . ." *Id.* at 1873-74. The *Smith* decision thus enables a capital defendant to bar a government psychiatric examination on the issue of future dangerousness.

The instant case raises the two issues left unresolved in *Jurek* and *Smith*. These are, first, whether a psychiatrist, testifying as an expert medical witness, may ever be permitted to render a prediction as to a capital defendant's long-term future dangerousness. The second issue is whether such testimony may be elicited on the basis of hypothetical questions, even if there exists no general prohibition against the use of expert psychiatric testimony on the issue of long-term future dangerousness. Amicus believes that both of these questions should be answered in the negative.

I. Psychiatrists should not be permitted to offer a prediction concerning the long-term future dangerousness of a defendant in a capital case, at least in those circumstances where the psychiatrist purports to be testifying as a medical expert possessing predictive expertise in this area. Although psychiatric assessments may permit short-term predictions of violent or assaultive behavior, medical knowledge has simply not advanced to the point where long-term predictions—the type of testimony at issue in

this case—may be made with even reasonable accuracy. The large body of research in this area indicates that, even under the best of conditions, psychiatric predictions of long-term future dangerousness are wrong in at least two out of every three cases.

The forecast of future violent conduct on the part of a defendant in a capital case is, at bottom, a lay determination, not an expert psychiatric determination. To the extent such predictions have any validity, they can only be made on the basis of essentially actuarial data to which psychiatrists, *qua* psychiatrists, can bring no special interpretative skills. On the other hand, the use of psychiatric testimony on this issue causes serious prejudice to the defendant. By dressing up the actuarial data with an "expert" opinion, the psychiatrist's testimony is likely to receive undue weight. In addition, it permits the jury to avoid the difficult actuarial questions by seeking refuge in a medical diagnosis that provides a false aura of certainty. For these reasons, psychiatric testimony on future dangerousness impermissibly distorts the fact-finding process in capital cases.

II. Even if psychiatrists under some circumstances are allowed to render an expert medical opinion on the question of future dangerousness, amicus submits that they should never be permitted to do so unless they have conducted a psychiatric examination of the defendant. It is evident from the testimony in this case that the key clinical determination relied upon by both psychiatrists was their diagnosis of "sociopathy" or "antisocial personality disorder." However, such a diagnosis simply cannot be made on the basis of a hypothetical question. Absent an in-depth psychiatric examination and evaluation, the psychiatrist cannot exclude alternative diagnoses; nor can he assure that the necessary criteria for making the diagnosis in question are met. As a result, he is unable to render a medical opinion with a reasonable degree of certainty.

These deficiencies strip the psychiatric testimony of all value in the present context. Even assuming that the diagnosis of antisocial personality disorder is probative of future dangerousness—an assumption which we do not accept—it is nonetheless clear that the limited facts given in the hypothetical fail to disprove other illnesses that plainly do not indicate a general propensity to commit criminal acts. Moreover, these other illnesses may be more amenable to treatment—a factor that may further reduce the likelihood of future aggressive behavior by the defendant.

ARGUMENT

Long concerned about potential abuses in capital sentencing, this Court has labored to assure that the death penalty "could not be imposed under sentencing procedures that created a substantial risk that it would be inflicted in an arbitrary and capricious manner." *Gregg v. Georgia*, 428 U.S. 153, 192 (1976) (plurality opinion). If that sentencing process is not to be undermined by reliance on groundless assertions of professional expertise, the practices at issue in this case should be struck down. As we will show, the psychiatric testimony that led to petitioner's death sentence was not the product of legitimate professional dispute. It was instead a distortion of expert opinion designed to mask the personal views of two individuals who happen to be psychiatrists.

While it is true that the use of expert testimony in state prosecutions is traditionally a matter of state evidentiary law, *see, e.g.*, J. Wigmore, *Treatise on Anglo-American System of Evidence in Trials at Common Law*, § 6e (3d ed. 1940), it is now recognized that capital punishment cases are constitutionally "different." *Gardiner v. Florida*, 430 U.S. 349, 357 (1977) (plurality opinion). It is of "vital importance to the defendant and to the community that any decision to impose the death sentence be, and appear to be, based on reason rather than caprice or emotion." *Id.* at 358. "[T]he penalty of death is

qualitatively different from a sentence of imprisonment, however long. . . . Because of that qualitative difference, there is a corresponding difference in the need for reliability in the determination that death is the appropriate punishment in a specific case." *Woodson v. North Carolina*, 428 U.S. 280, 305 (1976) (plurality opinion). In amicus' view, the psychiatric testimony given in this case cannot be squared with these basic constitutional principles.

I. The Use of Psychiatric Testimony in a Capital Case on the Issue of a Defendant's Long-Term Future Dangerousness is Constitutionally Invalid Because it Undermines the Reliability of the Factfinding Process.

Contrary to the claims of the prosecution psychiatrists who testified in this case, psychiatric predictions of long-term future dangerousness—even under the best of conditions and on the basis of complete medical data—are of fundamentally low reliability. Although a likelihood of future violent behavior may be assigned to a given individual solely on the basis of statistical "base rates" and other information of an actuarial nature, psychiatric determinations in this area have little or no independent validity. We believe, therefore, that diagnoses of "sociopathy" or "antisocial personality disorder," and predictions of future behavior characterized as "medical opinions," serve only to distort the factfinding process. Because the prejudicial impact of such assertedly "medical" testimony far outweighs its probative value, it should be barred altogether in capital cases.[6]

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[6] In *Estelle v. Smith*, *supra*, 101 S. Ct. at 1879, the Court stated in passing that "[w]hile in no sense disapproving the use of psychiatric testimony bearing on the issue of future dangerousness, the holding in *Jurek* was guided by recognition that the inquiry mandated by Texas law does not require resort to medical experts." To the extent this *dicta* suggests that psychiatric testimony on long-term dangerousness may be admitted as *expert* testimony, we believe that it should not be followed.

The unreliability of psychiatric predictions of long-term future dangerousness is by now an established fact within the profession.[7] In the early 1970s the American Psychiatric Association appointed a Task Force of distinguished psychiatric experts "to assemble the body of knowledge concerning the individual violent patient and the clinical issues surrounding his case." American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual, *Clinical Aspects of the Violent Individual* at v (1974). The primary finding of this Task Force was that judgments concerning the long-run potential for future violence and the "dangerousness" of a given individual are "fundamentally of very low reliability." *Id.* at 23. The report flatly concluded that "the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists . . . to reliably predict future violence is unproved." *Id.* at 30.

This conclusion has been confirmed repeatedly by the research in the field, including research designed to establish the validity of psychiatric predictions of violent behavior. A 1975 monograph published by the National Institute of Mental Health, A. Stone, *Mental Health and*

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[7] Predictions of short-term future behavior are to be distinguished from predictions of long-term future dangerousness in this regard. In civil commitment cases, for example, as this Court recognized in *Addington v. Texas*, 441 U.S. 418 (1979), psychiatrists are commonly called on to make predictions about short-term prognoses, and such predictions sometimes include potential violence. The psychiatrist is able to evaluate the patient's current mental condition and to discern its likely effect on behavioral patterns, including potentially violent behavior in the near future. Such situations, however, are clinically different from predictions of long-term dangerousness because they are made in the context of specific and usually acute mental illnesses (for example, severe depression), and they are made with knowledge of the individual's short-run environmental situation, which may have a direct bearing on the likelihood that he will act dangerously. *See* Monahan, *Prediction Research in the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 Amer. J. Psychiatry 198 (1978).

Law: A System in Transition 27-36 (1975), determined that the professional literature demonstrated no reliable criteria for psychiatric predictions of long-term future criminal behavior. *Id.* at 29, citing, S. Halleck, *Psychiatry and the Dilemmas of Crime* 348 (1971); Sturup, *"Will This Man Be Dangerous?"* in DeReueck & Porter, *The Mentally Abnormal Offender* 17 (1968); Kozol, *et al.*, *The Diagnosis and Treatment of Dangerousness*, 18 Crime and Delinquency 371, 383 (1972).

A more recent monograph, also published by the National Institute of Mental Health, again found that psychiatrists were more often wrong than right in predicting violent behavior over an extended period of time. J. Monahan, *The Clinical Prediction of Violent Behavior* (1981). After a review of all major research published in the 1970s, the monograph concluded that no psychiatric procedures or techniques had succeeded in reducing the high rate of "false positive" predictions—that is, affirmative predictions of future violent behavior that are subsequently proven erroneous. Professor Monahan observed that, even allowing for possible distortions in certain of the research data, "it would be fair to conclude that the best clinical research currently in existence indicates that psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior over a several-year period . . ." *Id.* at 49.[3]

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[3] Accord, Schwitzgebel, *"Prediction of Dangerousness and its Implications for Treatment"* in W. J. Curran, A. L. McGarry, & C. S. Petty, *Modern Legal Medicine, Psychiatry, and Forensic Medicine* 784 (1980) ("the professional literature almost uniformly affirms low predictive accuracy with regard to the dangerousness of mental patients"). *See also* Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. Pa. L. Rev. 439 (1974); Ennis & Litwack, *Psychiatry and The Presumption of Expertise: Flipping Coins in The Courtroom*, 62 Calif. L. Rev. 693 (1974); Livermore, Malmquist, & Meehl, *On the Justifications for Civil Commitment*, 117 U. Pa. L. Rev. 17 (1968); Steadman & Cocozza, *Psychiatry, Dangerousness,*

The fact that psychiatrists are unable to predict future violent behavior does not mean that such predictions can never be made. Indeed, this Court's decision in *Jurek v. Texas, supra*, rejecting a vagueness challenge to the Texas future dangerousness standard, forecloses that argument. What we do contend, however, is that the long-term prediction of future dangerousness is an essentially lay determination that should be based not on the diagnoses and opinions of medical experts, but on the basis of predictive statistical or actuarial information that is fundamentally non-medical in nature. The psychiatric gloss on such data furnished by expert medical testimony provides little, if any, additional information to the jury.

Recent research indicates that the most reliable—although by no means dispositive—predictors of long-term future violent behavior are factors having nothing to do with psychiatric disorders or illnesses. Thus, for example, an individual's past history of violent criminal behavior correlates positively with future criminal behavior. *See* Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 American Psychologist 224-38 (1978); J. Monahan, *The Clinical Prediction of Violent Behavior, supra*, at 71. The more violent crimes a defendant has already committed, the more likely he is to engage in further criminal activity in the future.[9] Other factors that may be predictive of future

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and The Repetitively Violent Offender, 69 J. Crim. Law & Criminology, 226, 229-231 (1978); Wenck, Robinson, & Smith, *Can Violence Be Predicted?* 18 Crime and Delinquency 393 (1972).

[9] One study of approximately 45,000 criminal defendants in the Washington, D.C. metropolitan area found an extremely high probability of rearrest for a person with five or more previous arrests. See Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology, supra.* Another study determined that virtually all the violent crime committed by released mental patients is committed by individuals who had extensive criminal records prior to their hospitalization. Steadman, Cocozza, & Melick, *Explaining the Increased Crime Rate of Mental Patients: The*

violent behavior include age (a disproportionate amount of violent crime is committed by persons between ages fifteen and twenty);[10] sex (nearly 90 percent of all persons arrested for violent crimes are male);[11] and race (blacks account for 46 percent of all arrests for violent crime).[12] Still other factors that are characteristic of criminal recidivists are a history of drug or alcohol addiction[13] and persistent unemployment.[14] Significantly, one factor which demonstrably *fails* to correlate with recurring criminal activity is mental illness. *See* Monahan, *The Clinical Prediction of Violent Behavior*, *supra*, at 78.

Although there will always be difficulties in predicting future dangerousness, *Jurek v. Texas*, *supra*, 428 U.S. at 275-76, it is clear that relevant testimony concerning the above factors may be presented to a jury by persons having no credentials in the area of psychiatry. Information concerning the defendant himself—for instance, past criminal record and employment history—can obviously

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Changing Clientele of State Hospitals, 135 American Journal of Psychiatry 816-20 (1978). In this regard, researchers have found that a history of criminal behavior starting before age fifteen is particularly predictive of future violence.

[10] *See* F. Zimring, *Confronting Youth Crime: Report of the Twentieth Century Fund Task Force on Sentencing Policy Toward Young Offenders* (1978).

[11] *See* W. Webster, *Crime in the United States—1977* (Federal Bureau of Investigation, 1978).

[12] W. Webster, *Crime in the United States*, *supra*. *See also* C. Silberman, *Criminal Violence, Criminal Justice* 117-18 (1978). In referring to this factor, we do not intend to suggest that its usage would be constitutionally permissible or appropriate in a sentencing hearing.

[13] Pritchard, *Stable Predictors of Recidivism*, 7 Journal Supplement Abstract Service 72 (1977).

[14] Cook, *The Correctional Carrot: Better Jobs for Parolees*, 1 Policy Analysis 11-54 (1975); D. Pritchard, *Stable Predictors of Recidivism*, *supra*.

be presented by lay witnesses. To the extent statistical information is considered relevant and desirable, such evidence may be given by statisticians, actuaries or, perhaps ideally, by corrections officers having experience in statistically-based parole decisions. This testimony could even be given by psychiatrists, but only if it is clear that they are furnishing lay evidence, not medical evidence.

Provided with this non-medical evidence, the jury is capable of deciding whether the objective facts relating to a particular defendant create a sufficient likelihood of future dangerousness to warrant the most severe criminal sanction. "The task that a Texas jury must perform in answering the statutory question in issue is thus basically no different from the task performed countless times each day throughout the American system of criminal justice." *Jurek v. Texas*, *supra*, 428 U.S. at 276. This determination, as the Court has made clear, "does not require a resort to medical experts." *Estelle v. Smith*, *supra*, 428 U.S. at 276.

While adding little, if anything, to the factual evidence concerning the risk of future dangerousness, psychiatric opinions on this subject substantially prejudice the defendant in two ways. First, psychiatric testimony is likely to be given great weight by a jury simply because it is, or purports to be, a statement of professional opinion. A psychiatrist comes into the courtroom wearing a mantle of expertise that inevitably enhances the credibility, and therefore the impact, of the testimony. As stated in a recent federal district court decision involving precisely this issue, when a prediction of future dangerousness "is proffered by a witness bearing the title of 'doctor,' its impact on the jury is much greater than if it were not masquerading as something it is not." *White v. Estelle*, Civil Action No. H-81-1661 (S.D. Tex. Dec. 30, 1982) (Slip op. at 17). Accord, *People v. Murtishaw*, 175 Cal. Rptr. 738, 631 P.2d 446 (Cal. S. Ct. 1981).

Second, and more important, psychiatric predictions of violent conduct unduly facilitate a jury's finding of future dangerousness by providing a clinical explanation for what is, at best, only an assessment of statistical probabilities. A medical diagnosis of antisocial personality disorder is in essence a descriptive label for past aberrant behavior of a particular type. When stated to a jury, however, the term "sociopath" (or "antisocial personality disorder") conveys the erroneous impression of an endogenous disorder which bears a cause-and-effect relationship to similar, future behavior. Medical opinions in this area thus offer the jury a seductively facile—but wholly unfounded—explanation as to why a particular individual having the statistical "symptoms" of a recidivist will in fact be a recidivist. Psychiatrists testifying on the question of future dangerousness, in other words, tend to particularize actuarial data in a manner not permitted by the data themselves. The jury is told, in effect, that the defendant not only has the statistically relevant characteristics of persons who commit multiple criminal acts, but that he *is* such a person.

The prejudice resulting from this distortion is significant. "Since the members of the jury will have had little, if any, previous experience in sentencing, they are unlikely to be skilled in dealing with the information they are given." *Gregg v. Georgia, supra*, 428 U.S. at 192. Nor can cross-examination or rebuttal experts limit or remove this prejudice. Because most psychiatrists do not believe that they possess the expertise to make long-term predictions of dangerousness, they cannot dispute the conclusions of the few who do. Instead of offering a countervailing prediction of nondangerousness in a particular case, they (or defense counsel on cross-examination) can only advance a challenge to the asserted "expertise" of the prosecution psychiatrist. The likely result, therefore, is that the jury will hear not the traditional battle of expert conclusions, but only a dispute over one expert's ability

to reach the conclusion that he did. In that situation it remains all too easy for the jury to avoid its difficult sentencing decision by seeking refuge in the only "medical" conclusion concerning dangerousness that is before it.

In sum, psychiatric predictions of long-term future dangerousness have little or no probative value and yet exact an incalculable cost in prejudice to a capital defendant. Amicus submits that under these circumstances the constitutional calculus is clearcut: except where restricted to testifying as essentially lay witnesses, psychiatrists should be prohibited from advancing predictions of long-term future violent behavior at the sentencing stage of a capital case.

II. At a Minimum, Psychiatrists Should Not Be Allowed to Offer Medical Opinions Concerning the Likelihood of Long-Term Future Dangerousness Unless They Have Conducted an In-Depth Psychiatric Examination of the Defendant.

Even if this Court determines that psychiatric testimony in this area has sufficient predictive value to outweigh its prejudicial impact, the psychiatric testimony given in this case was constitutionally defective for the separate reason that it was elicited on the basis of a hypothetical question. In our view, the use of hypothetical questions is no substitute for an in-depth psychiatric examination and evaluation, particularly where the consequences of an incorrect diagnosis and prediction are so obviously grave.[15]

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[15] We recognize that there are times when psychiatric testimony may not be based on an examination of the defendant—for instance, when a psychiatrist testifies concerning an individual's mental state at the time he executed a will. In such circumstances, the psychiatrist must make reasonable efforts to secure the requisite facts by relying on external information, including medical records, where available, and information derived from third parties. While such an approach is doubtless less reliable than testimony based on an examination, it is essentially a "best evidence" accommodation

It is apparent from the testimony in this case that the key factor relied on by the psychiatrists in making their prediction of future dangerousness was their diagnosis of antisocial personality disorder—a diagnosis which, in their view, means that petitioner is, and necessarily will remain, a criminal recidivist.[16] That diagnosis, however, cannot be made on the basis of the evidence presented. The same evidence fails to disprove other diagnoses that clearly do not indicate a general propensity for violent behavior and, in contrast to antisocial personality disorder, may be amenable to effective treatment.[17] Moreover, the evidence relied on for the diagnosis in this case was insufficient even to satisfy the basic criteria for antisocial personality disorder, much less to rule out alternative disorders. In short, hypothetical questions serve only to further distort the factfinding process in capital cases

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where the individual is unavailable and yet some determination must be made. In the capital sentencing situation, by contrast, the external information available is controlled by the prosecutor. Indeed, in the present case it appears that the psychiatrists did not even attempt to examine petitioner; nor did they look at the results of a psychological test that had been performed on petitioner in connection with a previous proceeding. *See* transcript of hearing on petitioner's federal district court habeas petition, *Barefoot v. Estelle*, Civil Action No. W-81-CA-191 (July 28, 1982) (W.D. Tex.). Where the death penalty is at issue, far greater efforts and reliability should be demanded. See pages 24-25 *infra*.

[16] For the reasons stated in the first part of this brief, amicus believes that no mental illness or disorder—antisocial personality disorder included—is reliably predictive of future violent or assaultive behavior. Our argument here of course assumes that the Court determines otherwise and finds that psychiatrists may offer testimony purporting to predict violent behavior on the basis of a diagnosis of antisocial personality disorder.

[17] This is not to suggest that any treatment can "cure" an individual's propensity toward violence. There are, however, established treatments for illnesses such as schizophrenia, depression, and alcoholism which might have a bearing on future behavior in a way that decreases the likelihood of violence. Such a consideration would obviously be relevant to a jury.

because they fail to provide sufficient information to make the diagnosis that forms the basis for the ultimate prediction.[18]

Although hypothetical questions in this context may contain sufficient information to render an opinion which is consistent with the assumed facts, they do not contain sufficient information to render that opinion with any reasonable degree of medical certainty. The psychiatric diagnostic technique is essentially an inductive process. *See* A. Elstein, L. Shulman, & S. Sprafka, *Medical Problem Solving: An Analysis of Clinical Reasoning* (1978). Beginning with a list of possible explanations for particular symptoms or complaints, psychiatrists are taught to ask patients a series of questions, the answers to which will rule out some possible explanations and increase the likelihood that other explanations account for the phenomenon—for example, a psychotic disorder, alcoholism, or depression.

As the examination proceeds, the psychiatrist builds on answers to past questions. In this manner, the range of possibilities is narrowed and the questions become increasingly specific. By focusing questions in a particular area, the psychiatrist searches for crucial additional data that will confirm or exclude one or more of the remaining possible explanations. Thus, for example, the explanation of psychosis is rendered unlikely by the determination that the patient has not experienced delusions or hallucinations. And determining whether the patient has had such

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[18] Assuming that, contrary to the position stated in the first section of our brief, psychiatric testimony may be used in capital sentencing on the issue of future dangerousness, we believe that a defendant's use of such testimony should be conditioned on his participation in an examination by prosecution psychiatrists. This Court intimated as much in *Estelle v. Smith, supra*, 101 S. Ct. at 1874 n. 10, 1878. This would eliminate the need for the prosecution to rely on hypotheticals where the defendant himself presents psychiatric testimony in an attempt to rebut the prosecution's claim of future dangerousness.

hallucinations or delusions generally requires careful questioning.

Ideally this inductive process leads eventually to the identification of a single explanation that is both supported by the existing data, and not disproven by the answers to the questions asked. Where this is not the case, and two or more possible explanations remain, the medical expert may still be able to make a judgment as to which of these possibilities is most likely, depending on the specificity of the data that has already been collected. In the clinical setting, this tentative diagnosis may then be further refined on the basis of the patient's observed response to the treatment plan that is adopted.

Viewed in this context, the diagnostic technique employed by the prosecution psychiatrists in this case is completely unacceptable. Although the diagnosis offered by Drs. Holbrook and Grigson was not inconsistent with the facts provided in the hypothetical, the prosecutor's question contained no information that would have permitted the psychiatrists to rule out other mental disorders—that is, possible alternative explanations for the behavior described. In this connection it should be noted that the standard diagnostic criteria for antisocial personality disorder include a determination that the patient is not suffering from schizophrenia or manic-depressive episodes. *See* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 321 (3d ed. 1980). However, little if any of the data stated in the hypothetical question related at all to these alternative disorders, and nothing whatever in the hypothetical could have provided a basis for excluding them.

It is thus apparent that the psychiatrists not only assumed as true the facts given in the hypothetical, but that they also assumed the nonexistence of unstated facts that might have pointed to a different conclusion. For example, both Dr. Holbrook and Dr. Grigson presumably assumed that petitioner had no history of delusions or

hallucinations—symptoms that might have suggested the alternative diagnosis of schizophrenia—simply because the hypothetical question contained no information in that regard. There was no basis for that assumption, as far as the record indicates. Of course, whether or not petitioner had in fact suffered from such symptoms could have been determined on the basis of a psychiatric examination.

Not only was the evidence presented in the hypothetical insufficient to rule out alternative diagnoses, it was also insufficient to meet the basic criteria for the diagnosis offered. *See* American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, supra,* at 320-21. The first, and perhaps most important, of these criteria is a history of severe antisocial behavior before age fifteen. However, a close reading of the hypothetical question given in this case discloses no information whatever about petitioner before age twenty-four. On this basis alone the diagnosis rendered by the prosecution psychiatrists is highly questionable. By conducting an examination, in contrast, this relevant information could have been readily ascertained.

The second criterion for a diagnosis of antisocial personality disorder requires positive findings of at least four of the following manifestations of antisocial behavior: (1) inability to sustain consistent work behavior; (2) lack of ability to function as a responsible parent; (3) failure to accept social norms with respect to lawful behavior; (4) inability to maintain enduring attachment to a sexual partner; (5) irritability and aggressiveness as indicated by repeated physical fights or assaults; (6) failure to honor financial obligations; (7) failure to plan ahead or impulsivity; (8) disregard for the truth as indicated by repeated lying; and (9) recklessness, as indicated by driving while intoxicated. *Ibid.*

Despite its considerable length, the prosecutor's hypothetical question in this case contained information regarding *only two* of these manifestations. Specifically,

the hypothetical recounted petitioner's past criminal behavior (evidencing the third manifestation), and also described certain deceitful and manipulative conduct occurring shortly before the murder (evidencing the eighth manifestation). Although petitioner's actual history may well have evidenced additional manifestations of antisocial behavior, the hypothetical question simply provided no basis for this assumption. Again, such diagnostic information could have been obtained—and undoubtedly would have been obtained—on the basis of a psychiatric examination.

The last criterion for a diagnosis of antisocial personality disorder requires the finding of an uninterrupted pattern of antisocial behavior from age fifteen to the time of the diagnosis. *Ibid.* As stated above, the prosecutor's hypothetical question contains *no* data at all concerning petitioner's behavior before age twenty-four—the period that is perhaps the most important for this diagnosis. Accordingly, the medical opinions of the prosecution psychiatrists fail to meet this last criterion as well.

To be sure, Drs. Holbrook and Grigson did not purport to be strictly applying these generally established diagnostic criteria. Leaving aside the question whether these witnesses should have been permitted to define antisocial personality disorder as they pleased, their testimony fares little better even under their own homemade criteria. Dr. Holbrook, for instance, defined a sociopath as "one who continues to demonstrate from early life into adulthood antisocial behavior." (Tr. 2098). He also stressed the failure to establish "loyalties to the normal institutions such as family, friends, politics, law or religion," and explained that through the manipulation of other people the criminal sociopath succeeds in "enhancing [his] own ego image . . . . It makes [him] feel good." *Ibid.*

Again, the hypothetical question contains little, if any, information that would permit Dr. Holbrook to ascribe these characteristics to petitioner. As stated, the hypo-

thetical is completely silent with respect to petitioner's behavior, antisocial or otherwise, during his "early life." Similarly, the information stated by the prosecutor said virtually nothing about petitioner's loyalties to family, religion, or other institutions. Nor is there any basis in the hypothetical question for Dr. Holbrook's assertions regarding the motives underlying petitioner's assertively manipulative conduct. Without an opportunity to interview petitioner, it would ordinarily be impossible to say what sorts of activities he derived pleasure from.

Dr. Grigson also gave his own criteria for determining whether or not someone has an "antisocial personality disorder." (Tr. 2128). Dr. Grigson stated that the most "outstanding characteristic" of persons fitting this diagnosis is the complete "lack of a conscience"—a deficiency that, in his view, causes such persons to be "only interested in their own self pleasure [and] gratification." *Ibid.* Indeed, it appears that a defendant's conscience, or lack thereof, is virtually the only consideration for Dr. Grigson's diagnosis of antisocial personality disorder; he ascribes relatively little weight to a defendant's past criminal behavior.[19]

A determination concerning an individual's lack of conscience is especially dependent on an in-depth psychiatric examination. It involves a subtle exploration into individual motive, gratification, and need across a wide spectrum of thoughts and activities. What little information was stated concerning petitioner's capacity for remorse, guilt, and similar emotions was wholly insufficient to conclude that petitioner was without a "conscience." Nor was there any basis for the inferences concerning the motives for petitioner's manipulative behavior. In the

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[19] In *Estelle v. Smith, supra,* for example, Dr. Grigson concluded that the defendant was "a severe sociopath" even though his only prior criminal conviction had been for possession of marijuana. 101 S. Ct. at 1870 n. 4, 1871.

absence of an examination, Dr. Grigson simply could not have known whether such activity was a source of gratification to petitioner or, if so, whether that was the only reason that he engaged in such activity.

The deficiencies in the psychiatric testimony in this regard will not be cured by improving or expanding on the hypothetical question format employed by the prosecution. It is inconceivable that the record in a criminal case can contain the type of diagnostic data needed to construct a hypothetical that would allow the rendering of a valid psychiatric opinion concerning antisocial personality disorder or related illnesses. Unless he has access to information derived from an in-depth psychiatric examination, a prosecutor is simply unable to state whether the defendant has experienced hallucinations or delusions, or to provide other diagnostic information minimally necessary to reach a reasonable psychiatric conclusion.

For many of the same reasons, cross-examination or rebuttal witnesses are not an adequate response to the problem posed by the use of hypotheticals in a capital sentencing proceeding. Since the information provided is so limited, a rebuttal psychiatrist cannot establish a contradictory diagnosis; at best he is reduced to contesting the first psychiatrist's ability to make the diagnosis that he did. Obviously cross-examination offers even less of an opportunity to dispute the initial diagnosis. The jury is thus left with only one opinion, challenged as to the adequacy of its basis but not as to its accuracy. Such a situation is necessarily biased against the defendant.

In sum, the inadequate procedures used in this case allow a psychiatrist to masquerade his personal preferences as "medical" views, without providing a meaningful basis for rebutting his conclusions. In a capital sentencing case the gravity of the jury's decision demands that its deliberations not be distorted by such practices.

CONCLUSION

For the foregoing reasons, amicus the American Psychiatric Association respectfully submits that the decision below should be reversed.

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